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July 26, 2012

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Proposed DME Face-to-Face Encounter Rule Means See More, Spend More, Save More for Medicare

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CMS released a proposed rule requiring written documentation of face-to-face encounters between physicians (and mid-level providers) and patients for certain high-risk durable medical equipment (DME) in the 2013 Proposed Physician Fee Schedule [PDF]. CMS expects that face-to-face encounters will decrease the number of fraudulent and inappropriate claims by DME suppliers. The increased encounters should result in increased Medicare Part B funds spent on additional physician visits; however, CMS expects to save Part B funds by preventing fraudulent and inappropriate Medicare Part B payments to DME suppliers. Physicians, DME suppliers, and other health care providers may comment on the proposed regulations **until September 30, 2012**.

According to the proposed rule a DME supplier will be reimbursed by Medicare for certain high-risk DME ("Specified Covered Items") only if a face-to-face encounter has occurred between the physician or mid-level practitioner (physician's assistant, nurse-practitioner or clinical nurse specialist) and the patient and the encounter has been documented. The DME supplier must receive and maintain both the DME order and the documentation of the encounter for at least seven years.

The encounter must include an evaluation of the beneficiary and include either a needs assessment for the DME or provide treatment for a medical condition that supports the need for the DME. The proposed rule also states that the DME order must include the following: (i) the beneficiary's name, (ii) the DME item, (iii) the NPI and signature of the ordering physician or practitioner, (iv) the date of the order,

(v) the diagnosis, and (vi) any applicable and proper usage instructions. A single face-to-face encounter can support more than one order for DME provided that the encounter documents the need for each DME order.

However, CMS recognized that in order to save money on inappropriate or fraudulent DME orders, Medicare might have to spend money first. CMS explained in the commentary to the proposed rule that some DME orders did not occur after a face-to-face encounter, even though many physicians conducted face-to-face encounters, and that the proposed rule would result in an increased number of physician or mid-level providers conducting and documenting face-to-face encounters. A new G-code would be established to compensate physicians for documenting face-to-face encounters by mid-level practitioners.

CMS also proposed that a "see-the-face" encounter would suffice as a face-to-face encounter if telehealth services were used. The face-to-face requirement would be satisfied by telehealth services furnished to an eligible telehealth beneficiary in an originating site. CMS proposed that these encounters would need to occur in rural areas and be billed by the practitioner with an approved Medicare telehealth billing code.

The encounter would be valid if it occurred no more than 90 days before the order for DME is written or within 30 days after the order is written. CMS explained in its comments to the proposed rule that it may not be possible to conduct the encounter before the DME order every time.

In contrast to a "see-the-face" encounter via telemedicine, a "supervise-the-face" encounter would not be acceptable for reimbursement of Specified Covered Items. CMS proposed that an encounter billed as an "incident to" service would not qualify as the face-to-face encounter.

CMS requested comments about how to document the face-to-face encounter. CMS proposed that a medical record that properly documented a face-to-face

examination would be sufficient. CMS also requested comments from stakeholders whether a separate signed physician's attestation of the encounter, a physician's signature on the medical record, or physician's initial by the history and physical examination would be sufficient.

CMS also sought comment about how the documentation should be delivered to the DME supplier. CMS proposed the following delivery methods: (i) the practitioner who wrote the order provides the documentation of the encounter to the DME supplier; (ii) the physician who completes the documentation of the encounter supplies the documentation; (iii) the documentation and the order travel together to the DME supplier, regardless of who delivers it; and (iv) the physician provides a copy of the documentation to the beneficiary so that the beneficiary can deliver the documentation to the DME supplier of choice.

Only certain Specified Covered Items, and no prosthetics or orthotics, were included in the proposed rule. Specified Covered Items included those DME that were likely to result in a savings to Medicare from inappropriate or fraudulent billing. Accordingly, DME that met at least one of the following four criteria were included as Specified Covered Items: (i) items costing more than $1,000, (ii) items determined by the DME Medicare Administrative Contractor to be susceptible to fraud, waste or abuse, (iii) items determined by CMS to be susceptible to fraud, waste or abuse, and (iv) items that currently require a written order prior to delivery in accordance with the Program Integrity Manual. The proposed rule specifically included the following items: transcutaneous electrical nerve stimulation (TENS) units, rollabout chairs, wheelchair accessories, oxygen and respiratory equipment, hospital beds and accessories, and traction-cervical devices. CMS explained that future adjustments to the list would occur automatically for those items that cost more than $1,000 and that prosthetics and orthotics could be added in the future.

Ober|Kaler's Comments

CMS' proposed regulations seek to implement the face-to-face encounter requirement in the Patient Protection and Affordable Care Act. DME suppliers and physicians both should consider the economic impact of the proposed rule and consider providing their comments to CMS before September 30, 2012.

The face-to-face encounter requirement will require physicians and DME suppliers to spend more time on administrative functions. DME suppliers will be most affected by the proposed rule because the DME suppliers will be required to obtain and maintain the documentation of the face-to-face encounter and the order for at least seven years. DME suppliers will need to be aware that "incident to" services will not meet the face-to-face requirement for DME reimbursement. Physicians may be able to offset the increased administrative cost with the new G code.

Physicians and DME suppliers should also consider the types of DME included in the Specified Covered Items list. More subtly, CMS proposes to adjust the $1,000 DME threshold only in proposed rulemaking, which means that if the cost of DME increases due to inflation or other market forces, more and more DME could be added to the Specified Covered Item list automatically without stakeholder comment.

Prosthetic and orthotics suppliers and physicians who order prosthetics or orthotics should also review the DME proposed rule to better prepare themselves if and when CMS issues regulations requiring face-to-face encounters for high risk prosthetics and orthotics.